

Employment Discrimination Complaint Intake Questionnaire



Governor Napolitano's Office of Equal Opportunity

State Capitol Building – Executive Tower
1700 West Washington, Suite 156
Phoenix, AZ 85007
(602) 542-3711 PH
(602) 542- 3712 FAX



Employment Discrimination Complaint/Intake Questionnaire

Please print your answers to the following questions. This form must be signed and dated on the back.

Complainant Information

Name: _____ Home Phone: () _____

Address: _____ Other Phone: () _____

City: _____ State: _____ Zip Code: _____ County: _____

Date of Birth: _____ E-mail: _____

Sex (M/F) _____ Social Security #: (Optional) _____

Basis on which you believe you have been discriminated against: (Circle all applicable)

Race Color Religion Sex National Origin Disability Age

Sexual Orientation Pregnancy Marital Status Retaliation Other _____

National Origin/or Ethnic Group: (Please Circle)

African American American Indian Arab, Afghani, Middle Eastern Asian American

East Indian Hispanic White Other _____

State Agency Against Which Complaint is Being Filed

State Agency/Employer: _____ # of Employees: _____

Address: _____ Phone: () _____

City: _____ State: _____ Zip Code: _____ County: _____

Division/Department: _____ Supervisor: _____

Supervisor's Phone #: () _____

- FOR OFFICE USE ONLY -

Initials of GOEO Officer: _____

Referred To: _____

Name: _____ SS# _____

Complaint/Discriminatory Incident(s) Description

In date order (chronologically), describe the harm or employer action for which you are filling a complaint. Be sure to include dates, times, names of witnesses, and what specifically was said and/or happened.

[illegible]

I swear to the best of my knowledge and belief that the information contained herein is complete and accurate.

Signature

Date

Request for Mediation



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Request for Mediation

Employee Information:

Name: _____ Home Phone: () _____

Address: _____ Other Phone: () _____

City: _____ State: _____ Zip Code: _____ County: _____

State Agency where you are employed:

State Agency/Employer/Dept: _____ # of Employees: _____

Address: _____ Phone: () _____

City: _____ State: _____ Zip Code: _____ County: _____

Supervisor: _____ Supervisor's Phone #: () _____

Reason for Mediation:

Signature _____

Date _____